(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,

(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,

(E) All secondary diagnoses,

(F) All procedures performed,

(G) Discharge status of the patient, and

(H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites and independent laboratories:

(A) Diagnosis,

(B) Procedure code for each procedure, service or supply for each date of service, and

(C) Individual billed charge for each procedure, service or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

(A) Name and address of pharmacy where drug was dispensed,

(B) Name of drug,

(C) Drug Code for drug provided,

(D) Strength,

(E) Quantity,

(F) Date dispensed,

(G) Pharmacy receipt for each drug dispensed (including billed charge), and

(H) Diagnosis.

(b) Health care payment shall be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the following are specifically excluded from payment:

(1) Care as part of a grant study or research program,

(2) Care considered experimental or investigational,

(3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,

(4) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,

(5) Services provided outside the scope of the provider's license or certification, and

(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§ 17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) *Explanation of benefits (EOB).* When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides at a minimum, the following information:

(1) Name and address of recipient,

(2) Description of services and/or supplies provided,

(3) Dates of services or supplies provided,

(4) Amount billed,

(5) Determined allowable amount,

(6) To whom payment, if any, was made, and

(7) Reasons for denial (if applicable).

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0577.)

(Authority: 38 U.S.C. 101(2), 1801–1806, Pub. L. 105–114)

§ 17.904 Review and appeal process.

If a health care provider, Vietnam veteran's child or representative disagrees with a determination concerning provision of health care or a health care provider disagrees with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing within one year of the date of the initial determination to the Chief, Administrative Division, Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025. The request must state why it is concluded that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the

matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Director, Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses or modifies the previous decision. An appeal under this section would be considered as filed the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO §17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans Appeals.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0577.)

(Authority: 38 U.S.C. 101(2), 1801–1806)

§17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment, and that VA determines are necessary to adjudicate claims under §§17.900 through 17.905, must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1801–1806)

PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES FOR NON-SERVICE-CONNECTED CONDITIONS IN NON-VA FACILITIES

SOURCE: 66 FR 36470, July 12, 2001, unless otherwise noted.

§17.1000 Payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities.

Sections 17.1000 through 17.1008 constitute the requirements under 38 U.S.C. 1725 that govern VA payment or reimbursement for non-VA emergency services furnished to a veteran for non-service-connected conditions.

(Authority: 38 U.S.C. 1725)

NOTE TO §17.1000: Health care providers furnishing emergency treatment who believe they may have a basis for filing a claim with VA for payment under 38 U.S.C. 1725 should contact VA within 48-hours after the veteran begins receiving emergency treatment. Such contact is not a condition of VA payment. However, the contact will assist the provider in understanding the conditions for payment. The contact may also assist the provider in planning for transfer of the veteran after stabilization.

§17.1001 Definitions.

For purposes of §§17.1000 through 17.1008:

(a) The term *health-plan contract* means any of the following:

(1) An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement under which health services for individuals are provided or the expenses of such services are paid;

(2) An insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of that Act (42 U.S.C. 1395j);

(3) A State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);

(4) A workers' compensation law or plan described in section 38 U.S.C. 1729(a)(2)(A); or

(5) A law of a State or political subdivision described in 38 U.S.C. 1729(a)(2)(B) (concerning motor vehicle accidents).

(b) The term *third party* means any of the following:

(1) A Federal entity;

(2) A State or political subdivision of a State;

(3) An employer or an employer's insurance carrier;

(4) An automobile accident reparations insurance carrier; or

(5) A person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.

(c) The term *duplicate payment* means payment made, in whole or in part, for